Universitätsklinikum Tübingen

Centre for Mental Health
Clinic of Psychiatry and Psychotherapy
Department of Psychiatry, Psychosomatics and Psychotherapy in Childhood and Adolescence

Medical director Prof. Dr. med. Renner
Osianderstraße 14-16
72076 Tübingen

Dear patients,

dear parents,

You have contacted us for an appointment at our outpatient clinic. To process the appointment smoothly, please fill out the required forms (registration and medical history sheet) and return them in full.

You will then be assigned to a consultation and placed on a waiting list. As soon as an appointment becomes available for you, we will contact you. Please understand that inquiries about wait times cannot be processed. Due to high demand, the wait time for an initial consultation is currently several months. We are aware of the importance of timely support and ask for your understanding of potential delays.

For families outside our catchment area (districts of Tübingen and Reutlingen), we will unfortunately not be able to offer initial appointments in the foreseeable future; in any case, expect significantly longer wait times. For a sooner referral to a psychiatric institute outpatient clinic, please contact the hospital providing care for your district. We strive to use our resources effectively and ensure the quality of our care. Thank you for your understanding.

With kind regards,

Frau Dr. H. Spieles
Senior physician ambulance

Frau Ida Steinacker
Therapeutic outpatient management

Herr Moritz Walz
Therapeutic outpatient management

Universitätsklinikum Tübingen

Registration

Application for:

☐ First consulting

☐ Follow-up appointment (had an appointment in the last 12 months)

☐ Second opinion

☐ Partial inpatient treatment

☐ Full inpatient treatment

To be filled out by the ambulance:

Appointment with: _____

Date:_____

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Contact of Outpatient Clinic Registration:
Tel.: +49 (0)7071 29-82338
Fax: +49 (0)7071 29-25146
Mail: ppkj@med.uni-tuebingen.de

Telephone office hours:
Monday – Thursday: 9-11 / 14-15:30 Uhr
Friday: 9-11 / 14-15 Uhr
Emergency contact:
Tel.: +49 (0)7071 29-62465

Child's information

Name: _____ Surname: _____

Date of birth: _____ ☐ male ☐ female ☐ non-binary

Child lives with ☐ both parents ☐ mother ☐ father ☐ _____

Contact information of mother	**Contact information of father**	**Contact information residential group / foster family / or similar**
Name: Address:	Name: Address:	Name: Address:
Telephone: Mobile: Mail:	Telephone: Mobile: Mail:	Telephone: Mobile: Mail:
Child custody ☐ yes ☐ no	**Child custody** ☐ yes ☐ no	**Child custody** ☐ yes ☐ no

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Insurance information (Data can be found on the insurance card): □ statutory (□ private)	
Name of health insurance: Number of health insurance:	Insurance number **(child):** Principal insurer + date of birth **(one parent):**
Video consultation – more information on p. 7	
We are willing to consider video consultation: □ yes □ no	Requirements: - Device with camera, microphone (PC, laptop, tablet, mobile phone), Internet access
Problems / symptoms / pre-diagnosis	
Further information – If so, please bring along previous findings	
First contact with our clinic?	□ yes □ no
Medical referral from children's hospital or Gynecology (DSD)?	□ yes □ no
Is your child currently taking any medication? If so, which one and how is it dosed?	□ yes □ no
Is there existing contact with another child and adolescent psychiatrist? If so, to whom? Is this contact ongoing?	□ yes □ no
Is there existing contact with another child and adolescent therapist? If so, to whom? Does this contact ongoing?	□ yes □ no
Has there already been an instance of inpatient child and adolescent psychiatric treatment? If so, when and where?	□ yes □ no
Has a psychological assessment already taken place? If so, where?	□ yes □ no

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This document is strictly required

Consent of the legal guardians

(The signatures of all guardians are required)

Name of the child: _____ Date of birth: _____

1. Consent to diagnostics and treatment

We hereby agree that our child will be examined, treated, and cared for in the Department of Psychiatry, Psychosomatics and Psychotherapy in Childhood and Adolescent Medicine at the University Hospital Tübingen.

_____	_____	
Name of custodial parent 1 (in block letters)	Place, date	Signature
_____	_____	
Name of custodial parent 2 (in block letters)	Place, date	Signature

2. Representation rule for appointment attendance and waiver of confidentiality

If only one custodial person is present at appointments, we expressly authorize this person to make decisions and provide explanations on behalf of the child (e.g., waiver of confidentiality).

We authorize

O the custodial mother/father: Name, First name _____

O the custodial mother/father: Name, First name _____

O other persons (e.g., foster parents, residential group): Name, First name _____

to consent to treatment and provide all necessary declarations.

This consent form can be revoked at any time in writing with immediate effect.

_____	_____	
Name of custodial parent 1 (in block letters)	Place, date	Signature
_____	_____	
Name of custodial parent 2 (in block letters)	Place, date	Signature

Universitätsklinikum
Tübingen

Declaration of consent
to photo or video recording / confidentiality / contact for study requests

Dear parents, dear patients,

since we care about the best possible diagnosis and treatment of your child, we ask for your consent to the following, which will make our work easier. Please refer to the enclosed information for further explanation.

Name of the child: _____

Date of birth: _____

For the period of diagnosis / treatment between my child or me and the staff of the child and adolescent psychiatry (please mark as applicable)

- ○ I agree to a picture being taken of my child with an instant camera.
- ○ I undertake to keep private information confidential to third parties.
- ○ I agree that video and audio recordings may be recorded for diagnostic and therapeutic purposes.
- ○ I agree that the video or audio recordings may be used for supervisory purposes within the child and youth psychiatry.

I agree to be contacted for study requests.

- ○ Contact for study requests

By signing, I acknowledge that each of these declarations have been made voluntarily. I have been informed that I have the right to revoke this statement at any time, informally in writing or orally. Participation in therapeutic measures can of course also take place if I do not agree to the use of the recordings and data.

_____
Place, date

_____ _____
Signature of parent / legal guardian Signature of parent / legal guardian

_____
Signature child

Information sheet for you to keep

Consent forms – information sheet

Instant image for filing
The instant image is to be taken at one of the appointments in our outpatient clinic. The recording is primarily for the recognition of your child. The image is stored in their file during diagnosis and treatment. The images are not saved after completion of the treatment. We will destroy them appropriately. Under no circumstances will personal data be passed on to third parties.

Confidentiality Obligation
As part of the treatment of your child, you may receive information about fellow patients that is very personal and not intended to be passed on to third parties. By signing, you agree to remain silent about this information. The obligation of confidentiality applies throughout and after treatment.

Image and sound recordings
Our clinic has the possibility to take pictures and sound recordings (photos, videos, tape recordings and so on). The records are used in accordance with the applicable data protection regulations and are subject to medical confidentiality.

Diagnostics and therapy: The primary aim of the image and sound recordings is to improve the quality of diagnosis, assessment and treatment. The quality of the treatment can be improved by a subsequent, precise examination by the interdisciplinary team.

Supervision and internal teaching: As a university hospital we are a training hospital, which means the training of doctors, therapists, nurses and so on is an important part of our work. Appropriate admission in meetings can contribute to the quality of treatment.

Contact for study requests
We conduct scientific studies to learn more about the causes of psychiatric illnesses and to expand our existing knowledge. This enables us to constantly improve our treatment. You could help us to develop the medical expertise that people with mental disorders can benefit from in the future. We would be happy if we could contact you and your child with regards to such studies. An employee would then contact you in order to present the study to you in detail.

Our studies are reviewed and approved by the responsible ethics committee. The participation in studies is voluntary. It is possible to refuse to participate in a study at any time – without giving reasons and without restricting healthcare and rights. You may also revoke your consent to be contacted by us regarding studies at any time. Your data will be treated confidentially and will not be passed on.

Universitätsklinikum Tübingen

Information sheet for you to keep

Video and telephone consultation

Increasingly, video and telephone consultation are also being used in our organization. We consider them to be an additional form of service we can offer. Personal appointments will continue alongside this new form of consultation. When registering and making an appointment, you can indicate whether video consultation is possible and feasible for you. If this is the case, you will usually receive a link via e-mail that allows you to access our video system.

To do this you need an internet-enabled device with microphone and camera. Please also check that your browser settings are enabled for this. Please ensure a quiet and well-lit environment for trouble- free implementation. Participation in the video consultation is voluntary and the use of the software is free of charge.

The program through which the video consultation is carried out is certified and approved by the health insurance companies. Data collection, processing and use for video consultation is carried out in accordance with the *Agreement on the Requirements for Technical Procedures for Video Consultation in accordance with Annex 31b to the Federal Coat Agreement* – Doctors SGB V.

We inform you hereby:

- That participation in the video consultation is voluntary for you/ your child and clinic staff.
- To ensure data security and trouble-free operation on both sides, the video consultation takes place in enclosed rooms that ensure adequate privacy.
- At the beginning of the video consultation session there is a presentation on both sides of all the persons present in the room.
- Recordings of any kind are not permitted during video consultation.
- During the consultation, the employees inform the participants of the requirements for the conduct of the video consultation (according to § 3 of the *Agreement on the Requirements for the Technical Procedures for the Video Consultation Hours according to Appendix 31 b of the Federal Coat Agreement* – Doctors SGB V).
- You consent to the collection, processing and use of your health data in the context of the video consultation by employees of the clinic; always in accordance with the applicable data protection regulations.
- You can revoke the consent of the employees of the clinic at any time without special formal requirements and deadlines.

Checklist

Necessary documents before the appointment:

Please send the following documents if available:

- ☐ Doctor's letters (copies)
- ☐ Therapy reports (copies)
- ☐ School behavior report (informal) from the class teacher
- ☐ Copies of report cards from the last 2 years
- ☐ Youth welfare reports (copies)

Necessary information and documents for the appointment:

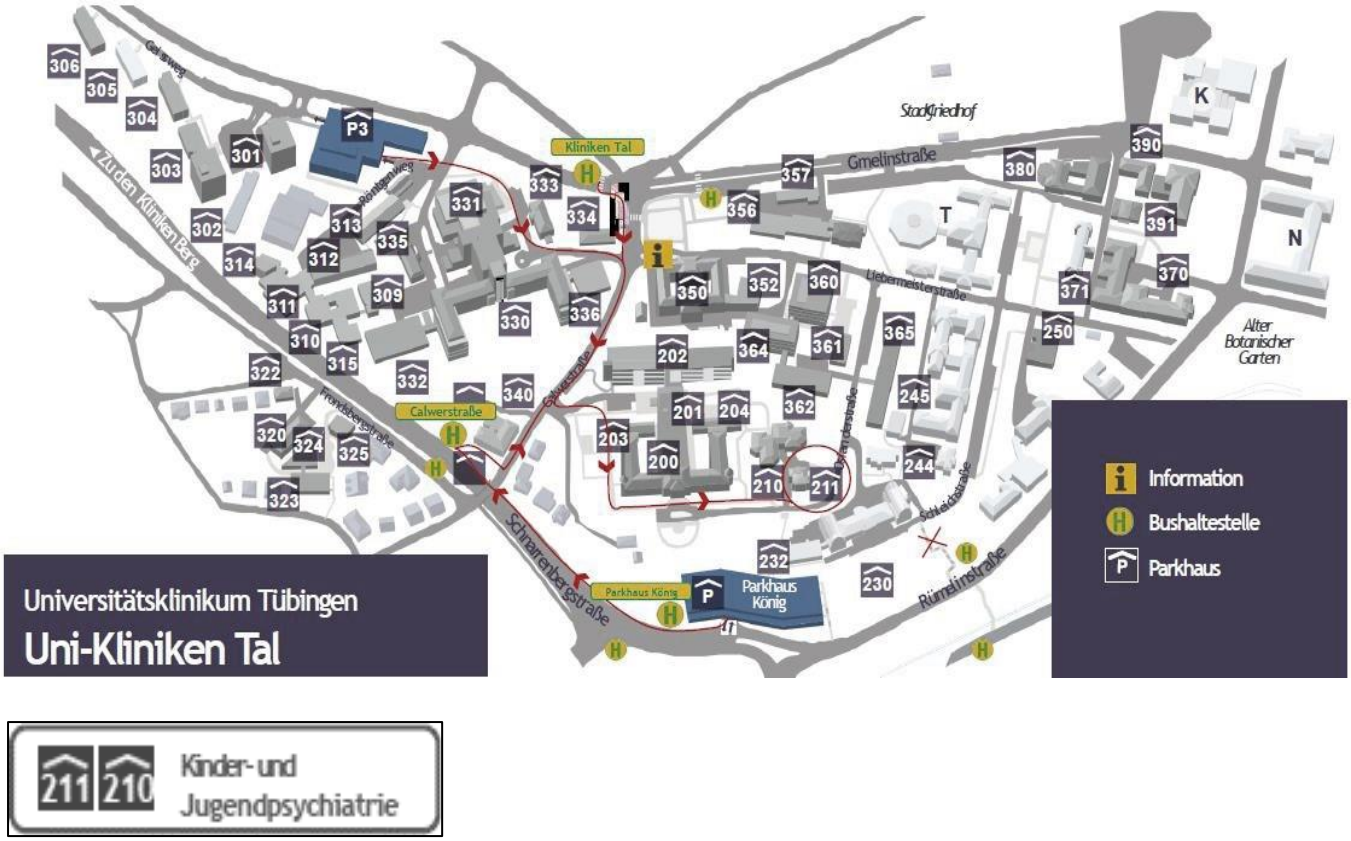
Please arrive **15 minutes before** your first appointment for registration.

- ☐ Referral from your child's or family doctor (necessary for each quarter!)
- ☐ Health insurance card
- ☐ Consent form from the parent or guardian with custody, who is **not attending** the appointment
- ☐ Consent form regarding video/photo/study contact
- ☐ Yellow medical screening book

Please note that due to construction measures around the site, the parking situation and footpaths are significantly restricted. Longer walking distances must be considered.

We kindly ask you to take this into account for your journey and to start earlier accordingly. We ask for your understanding. On the following page you will find information about footpaths and parking facilities.

Directions



Arrival by public transport:
Buses of the lines 5, 13, 18 und 19 leave directly on opposite of the central station of Tübingen.

Bus line 5:
Exit at the bus stop „Kliniken Tal“. Please cross the road, then follow the signs to „Psychiatrische Klinik“.
(footpath about 10 minutes)

Bus lines 13, 18 & 19:
Exit at the bus stop „Calwer Straße“. Please follow the signs to „Kliniken Tal“/ „Psychiatrische Klinik“.
(Footpath about. 10 minutes)

Arrival by car:
It is advisable to park either on „Schnarrenbergstraße” at the parking bays on the side of the road or in the car park P3
from the women’s hospital (inner city clinics, Röntgenweg 2) and follow the signs for „Psychiatrische Klinik”.

Please note that the entrance from the car park „Altstadt König” to our clinic is closed and not accessible. You can park in the car park „Altstadt König” and reach us on foot via Schnarrenbergstraße or Rümelinstraße.

MEDICAL HISTORY SHEET

Questionnaire completed on: _____ **by:** mother ☐ father ☐ _____

CHILD / YOUNG PERSON

First and last name	
Gender	☐ male ☐ female ☐ _____
Date of birth	
Place of birth	
Child lives with	☐ biological parents ☐ foster parents ☐ biological mother ☐ residential group ☐ biological father ☐ adoptive parents ☐ _____

Current school form: (primary school, community college, …) Grade: Class teacher:	Name and address of school: Phone number:

REASON FOR CONSULTATION AND AREAS OF CONCERN

Consultation initiated by:

☐ parents ☐ pediatrician / doctor ☐ psychotherapist: _____

☐ school ☐ kindergarten ☐ _____

Main Concern / reason for consultation:

When did the problems firs occur?

What are you most concerned about with regards to current problems?

What are your expectations from the consultation

HISTORY OF CHILD DEVELOPMENT		
COURSE OF PREGNANCY	**Total number of pregnancies**	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ ____
	If the number of siblings differs from the number of pregnancies: What problems occurred?	
	Special events, struggles during the pregnancy (unplanned pregnancy, death of relatives, separation, moving, …):	
	Complications during the course of pregnancy (bleeding, premature contractions, hospitalization, …):	
	Risks: ☐ smoking. If so, how many? ☐ alcohol consumption. If so, how much? ☐ drug consumption. If so, which drugs and how much?	
BIRTH	**Pregnancy week at delivery:**	
	Age of the mother at birth:	
	Complications during birth:	
	Birth weight: **Head circumference:**	**Height:** **APGAR:** **NapH:**
POSTPARTUM COURSE	**Complications after birth:**	
	Was your child breastfed?	☐ no ☐ yes, until the ☐☐ month of life

EARLY CHILDHOOD DEVELOPMENT

How did your child develop as an infant? (Eating habits / weight development / growth …)

AGE IN MONTHS			
	Motoric development of the child		
	Sitting alone	Standing alone	Walking freely
	Linguistic development of the child		
	Speaking first words	Forming simple sentences	
	Hygenic development of the child		
	Dry / clean during the day	Dry / clean at night	Fallbacks / relapses

Was there any evidence of developmental delays? If so, which ones?

If you compare the development of your child to other children of the same age, you would assess your child as:

☐ normal/ age appropriate in terms of development ☐ slower rate of development ☐ faster rate of development

DAY CARE / KINDERGARTEN

Is your child attending / did your child attend a day care center? (under the age of 3)

☐ yes, age at entry: ☐☐ years ☐☐ months

☐ no

Were there any anomalies?

☐ yes, which ones: _____

☐ no

Is your child attending / did your child attend a kindergarten?

☐ yes, age at entry: ☐☐ years ☐☐ months

☐ no, because:

Where there any problems when settling into kindergarten (e.g. separation fear / anxiety)?

☐ no ☐ yes, which ones:

How is your child getting along/ did your child get along with the other children in the kindergarten?	**How is your child getting along / did your child get along with the kindergarten teachers?**

Are / Were there any anomalies, difficulties or special events in kindergarten?

☐ no ☐ yes, which ones:

Did your child receive any external or additional support during kindergarten?

☐ skilled worker for integration ☐ others

Does / did your child like attending kindergarten?

☐ very much ☐ gladly ☐ medium ☐ not so much ☐ very reluctant

Was there a change of kindergarten?

☐ no ☐ yes, when (years; age of the child), why:

SCHOOL DEVELOPMENT

When was your child enrolled in school?

Year: Age of the child: ☐☐ years ☐☐ months

What school: _____

Were there any difficulties at school enrollment?

☐ no ☐ yes, which ones:

Are / Were there any anomalies, difficulties or special events during primary school time?

How is your child getting along/ did your child get along with the other children in primary school?	**How your child getting along/ did your child get along with the teachers in primary school?**

Has your child repeated a grade?

☐ no ☐ yes, which, why:

School enrollment in grade 5 (secondary school)

Year: Age of the child: ☐☐ years ☐☐ months

What school: _____

Was there a change of school?

☐ no ☐ yes, when (grade): what school: _____

Has your child repeated a grade in secondary school?

☐ no ☐ yes, which one: ☐ why:

How would you describe your child´s current social behavior in school?

How would you describe your child´s current performance in school?

☐ above average ☐ average ☐ below average

With regards to your child´s current academic performance, are you:

☐ satisfied ☐ mostly satisfied ☐ rarely satisfied ☐ unsatisfied

Grades of the last school report / semi-annual school report:

Math: German: English:

Does your child have any specific developmental disorders of scholastic skills (e.g. dyslexia, dyscalculia)?

☐ no ☐ yes, in which areas (e.g.: math, reading, spelling):

Has this been diagnosed before?

☐ no ☐ yes, which one, when:

STRESSFUL LIFE EVENTS FOR THE CHILD

Please describe (e.g. separation experience, death of an important reference person, birth of siblings, divorce of the parents, …)

☐ separation experience: _____ when:

☐ divorce of the parents: _____ when:

☐ death (important reference person): _____ when:

☐ birth of siblings: _____ when:

☐ accident: _____ when:

☐ _____ when:

FREE TIME BEHAVIOR AND EVERYDAY FAMILY LIFE

How often…	Everyday	About 3-5 times per week	About 1-2 times per week	Infrequent	Never
…does your child meet with other children (other than at school)?	☐	☐	☐	☐	☐
…does your child play outside?	☐	☐	☐	☐	☐
…is your child involved in regular leisure activities? (sports club, community work, musical instrument, …)	☐	☐	☐	☐	☐

What regular leisure activities does your child pursue? (e.g.: soccer, choir, scouts, …)

How much time does your child spend using media each day?

	Less than an hour	About 1-2 hours	About 3-4 hours	More than 4 hours	Not at all
Mobile / smartphone	☐	☐	☐	☐	☐
Computer / tablet / internet	☐	☐	☐	☐	☐
Television	☐	☐	☐	☐	☐
PlayStation / Wii / console	☐	☐	☐	☐	☐

How much time does your child spent with electronic media in total? (TV, PC, Tablet, Handy, etc.)

Monday to Friday: ⌊__⌋__ hours Weekend: ⌊__⌋__ hours

DISEASES AND ALLERGIES

Which diseases has your child had so far?

Which operations have been made so far?

Previous hospitalizations:

Chronic diseases	☐ asthma, since: _____ medication: _____ ☐ others: _____since: _____ medication: _____
Allergies	☐ medicines: _____ ☐ food: _____ ☐ grasses / trees: _____ ☐ animal hair: _____ ☐ others: _____
How long does your child sleep on average?	Per day: ☐☐ At night: ☐☐
How long does it take your child to fall asleep? ☐ 10-30 min. ☐ 30-60 min. ☐ 60-90 min. ☐ 90 -120 min. ☐ _____	**Does your child often wake up at night?** ☐ no ☐ yes, how often: ☐ why (e.g. nightmares, restless sleep, …): **How do you react?**

FAMILY		
	☐ **biological mother** ☐ **adoptive mother** ☐ **foster mother**	☐ **biological father** ☐ **adoptive father** ☐ **foster father**
First and last name		
Current address		
Phone number		
Mobile phone number		
Date of birth (age)		

Place of birth		
Nationality		
Learned occupation		
Current occupation		
Work scope hours/week		
Highest general educational qualification	☐ not yet graduated / still student ☐ graduated after a maximum of 7 years of school attendance ☐ Haupt-/Volksschule ☐ Realschule / Middle School Certificate / Polytechnic High School ☐ A-Levels, general or subject-specific university entrance qualification, extended secondary school, university entrance qualification / advanced technical college entrance qualification, city college ☐ other qualifications (e.g. obtained abroad): _____	☐ not yet graduated / still student ☐ graduated after a maximum of 7 years of school attendance ☐ Haupt-/Volksschule ☐ Realschule / Middle School Certificate / Polytechnic High School ☐ A-Levels, general or subject-specific university entrance qualification, extended secondary school, university entrance qualification / advanced technical college entrance qualification, city college ☐ other qualifications (e.g. obtained abroad): _____
Highest professional qualification	☐ no degree, still in vocational training, e.g. student, trainee, year of vocational preparation, internship ☐ no professional qualifications and no apprenticeship ☐ apprenticeship, i.e. vocational training ☐ training at vocational school, commercial school, i.e. vocational schooling ☐ technical school, e.g. master's school, technical school, vocational or technical academy ☐ University of Applied Sciences, Engineering School ☐ University or college ☐ other school leaving qualifications (e.g. obtained abroad): _____	☐ no degree, still in vocational training, e.g. student, trainee, year of vocational preparation, internship ☐ no professional qualifications and no apprenticeship ☐ apprenticeship, i.e. vocational training ☐ training at vocational school, commercial school, i.e. vocational schooling ☐ technical school, e.g. master's school, technical school, vocational or technical academy ☐ University of Applied Sciences, Engineering School ☐ University or college ☐ other school leaving qualifications (e.g. obtained abroad): _____
Gainful employment	☐ working fulltime ☐ working part-time ☐ marginally employed ☐ unemployed ☐ retired / early retirement since: _____	☐ working fulltime ☐ working part-time ☐ marginally employed ☐ unemployed ☐ retired / early retirement since: _____

Professional status (if currently not / no longer employed: professional status you held last)	☐ employee ☐ worker ☐ civil servant ☐ farmer in main occupation ☐ self-employed without employees ☐ self-employed with employees ☐ working for the family (unpaid) ☐ trainee, volunteer ☐ voluntary military service or federal voluntary service ☐ voluntary social / environmental / cultural year ☐ never been in an employment	☐ employee ☐ worker ☐ civil servant ☐ farmer in main occupation ☐ self-employed without employees ☐ self-employed with employees ☐ working for the family (unpaid) ☐ trainee, volunteer ☐ voluntary military service or federal voluntary service ☐ voluntary social / environmental / cultural year ☐ never been in an employment
Details of management and leadership duties/ authority to give instructions to employees who are not apprentices	☐ yes, as a manager (with decision-making authority over personnel, budget and strategy) ☐ yes, as supervisor (guiding and supervising staff, distributing and controlling work) ☐ no	☐ yes, as a manager (with decision-making authority over personnel, budget and strategy) ☐ yes, as supervisor (guiding and supervising staff, distributing and controlling work) ☐ no
Custody	☐ yes ☐ no	☐ yes ☐ no

LIVING SITUATION OF PARENTS	
☐ living together, since: _____ ☐ married, since: _____ ☐ living separately, since: _____	☐ divorced, since: _____ ☐ other family constellation: _____

FOR PARENTS LIVING SEPARATELY		
	Partner of mother	**Partner of father**
First and last name		
Date of birth (age)		
Place of birth		
Nationality		
Partnership since		
Living together since		
Learned occupation		

Current occupation		
Working Hours (hours/week)		
Highest general educational qualification	☐ not yet graduated / still student ☐ graduated after a maximum of 7 years of school attendance ☐ Haupt-/Volksschule ☐ Realschule / Middle School Certificate / Polytechnic High School ☐ A-Levels, general or subject-specific university entrance qualification, extended secondary school, university entrance qualification / advanced technical college entrance qualification, city college ☐ other graduations (e.g. obtained abroad): _____	☐ not yet graduated / still student ☐ graduated after a maximum of 7 years of school attendance ☐ Haupt-/Volksschule ☐ Realschule / Middle School Certificate / Polytechnic High School ☐ A-Levels, general or subject-specific university entrance qualification, extended secondary school, university entrance qualification / advanced technical college entrance qualification, city college ☐ other graduations (e.g. obtained abroad): _____
Highest professional qualification	☐ no degree, still in vocational training, e.g. student, trainee, year of vocational preparation, internship ☐ no professional qualifications and no apprenticeship ☐ apprenticeship, i.e. vocational training ☐ training at vocational school, commercial school, i.e. vocational schooling ☐ technical school, e.g. master's school, technical school, vocational or technical academy ☐ University of Applied Sciences, Engineering School ☐ University or college ☐ other school leaving qualifications (e.g. obtained abroad): _____	☐ no degree, still in vocational training, e.g. student, trainee, year of vocational preparation, internship ☐ no professional qualifications and no apprenticeship ☐ apprenticeship, i.e. vocational training ☐ training at vocational school, commercial school, i.e. vocational schooling ☐ technical school, e.g. master's school, technical school, vocational or technical academy ☐ University of Applied Sciences, Engineering School ☐ University or college ☐ other school leaving qualifications (e.g. obtained abroad): _____
Gainful employment	☐ working fulltime ☐ working part-time ☐ marginally employed ☐ unemployed ☐ retired / early retirement since: ____	☐ working fulltime ☐ working part-time ☐ marginally employed ☐ unemployed ☐ retired / early retirement since: ____
Professional status (if currently not / no longer employed: professional status you held last)	☐ employee ☐ worker ☐ civil servant ☐ farmer in main occupation ☐ self-employed without employees	☐ employee ☐ worker ☐ civil servant ☐ farmer in main occupation ☐ self-employed without employees

	☐ self-employed with employees ☐ working for the family (unpaid) ☐ trainee, volunteer ☐ Voluntary military service or federal voluntary service ☐ Voluntary social / environmental / cultural year ☐ never been in an employment	☐ self-employed with employees ☐ working for the family (unpaid) ☐ trainee, volunteer ☐ Voluntary military service or federal voluntary service ☐ Voluntary social / environmental / cultural year ☐ never been in an employment
Details of management and leadership duties/ authority to give instructions to employees who are not apprentices	☐ yes, as a manager (with decision-making authority over personnel, budget and strategy) ☐ yes, as supervisor (guiding and supervising staff, distributing and controlling work) ☐ no	☐ yes, as a manager (with decision-making authority over personnel, budget and strategy) ☐ yes, as supervisor (guiding and supervising staff, distributing and controlling work) ☐ no

RELATIONSHIP ARRANGEMENTS (IN CASE OF SEPARATED PARENTS)

☐ There is contact with the non-resident parent. How often?

☐ There is **no** contact with the biological father/mother. Since when and why?

Contact arrangements were arranged by:

☐ parents with each other / by mutual agreement ☐ advice center ☐ Youth welfare office

☐ court ☐ _____

How satisfied are you with the existing contact arrangements?

☐ very satisfied ☐ satisfied ☐ unsatisfied

Other living situation:

☐ lives with the grandparents **main contact person:** _____

☐ lives in a residential group

SIBLINGS

	1	**2**	**3**	**4**	**5**
First name					
Last name					
Date of birth					
Relationship	☐full-siblings ☐half-siblings ☐step-siblings	☐full-siblings ☐half-siblings ☐step-siblings	☐full-siblings ☐half-siblings ☐step-siblings	☐full-siblings ☐half-siblings ☐step-siblings	☐full-siblings ☐half-siblings ☐step-siblings
In case of half-siblings / step-siblings	☐ maternal ☐ paternal	☐ maternal ☐ paternal	☐ maternal ☐ paternal	☐ maternal ☐ paternal	☐ maternal ☐ paternal

Class; **type of school or school leaving certificate**					
Apprenticeship /occupation					
Are there any problems, abnormalities or diseases? **If so, which ones?**	Physical: Mental / behavioral:	Physical: Mental / behavioral:	Physical: Mental / behavioral:	Physical: Mental / behavioral:	Physical: Mental / behavioral:
Does the child / youth live in the same household? (yes / no)					

KNOWN DISEASES AND ABNORMALITIES IN THE FAMILY

Which physical and mental illnesses are known to occur in the family?	Biological father	Biological mother	Grandma (maternal / paternal)	Grandpa (maternal / paternal)	Other relatives
	physical: mental:	physical: mental:	physical: m: p: mental: m: p:	physical: m: p: mental: m: p:	physical: m: p: mental: m: p:
Attempted suicide **Completed suicide**	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐

PREVIOUS APPROACHES / TREATMENTS

What recommendations have been made so far (by pediatrician, school, therapist, …)?

What have you or others (e.g. school, …) already tried to improve the problematic behavior?

Previous treatments / therapies (e.g.: early education, psychotherapy, occupational therapy, learning therapy, medication)			
Type of treatment (In case of therapy: type and name of therapist/doctor in case of medication: name and dose of medication)	**Age** (at beginning)	**Duration** (months and frequency/ number of contacts)	**Where / What exactly?**
Occupational therapy			
Speech therapy			
Learning therapy			
Psychological information center			
Outpatient psychotherapy			
Type of treatment (In case of therapy: type and name of therapist/doctor in case of medication: name and dose of medication)	**Age** (at beginning)	**Duration** (months and frequency/ number of contacts)	**Where / What exactly?**
Child psychiatric treatment			
psychotherapy in a day clinic			
Inpatient psychotherapy			
Outpatient crisis intervention / emergency consultation			
Inpatient crisis intervention			
Medication			**Name:** **Dose:**
Other treatments			
Previous diagnoses (if known):			
YOUTH WELFARE OFFICE			
Is or your family or has your family been in contact with youth welfare services? ☐ no ☐ yes			

If so, which youth welfare office was / is responsible?

☐ Tübingen ☐ Reutlingen ☐ _____

Responsible contact person:

Name: _____

Phone number: _____

Type of assistance provided by youth welfare services:	**Start date and scope (hours per week) of assistance:**
☐ Counseling	☐ _____
☐ Aufsuchende sozialpädagogische Familienhilfe (SPFH)	☐ _____
☐ Educational supervisor	☐ _____
☐ Intensive case-by-case assistance	☐ _____
☐ Family therapy	☐ _____
☐ Day care group	☐ _____
☐ Residential group	☐ _____
☐ _____	☐ _____
☐ _____	☐ _____

Has your child had a hospitalization of four days or more in the past 12 months?	☐ no ☐ yes

If your child is to be considered for an inpatient stay in our clinic or a stay in our day clinic, we kindly ask you to check their vaccination certificate with your pediatrician before admission. If there are upcoming vaccinations, please arrange for them to be taken immediately.
Please bring the vaccination certificate with you to the preliminary interview.

Are there things that have not been mentioned so far but could be important in order to better understand the problem?

If you wish, you can list your expectations here:

Thank you very much!